

**DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS**

**FINAL REPORT
OF A
NON-ROUTINE MEDICAL SURVEY
OF
KAISER FOUNDATION HEALTH PLAN, INC.
A FULL SERVICE HEALTH PLAN**

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**Final Report of Non-Routine Medical Survey
Kaiser Foundation Health Plan, Inc.
A Full Service Health Plan
July 28, 2006**

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the “Department”) conducted a non-routine medical survey of Kaiser Foundation Health Plan, Inc. (the “Plan”). The on-site survey was conducted at the Northern California Kidney Transplant Center Kaiser in San Francisco, California on May 16 and 17, 2006.

For purposes of this Final Report, the term “Kaiser” shall be defined as the integrated health care system which includes the Plan, The Permanente Medical Group, the Plan’s contracting medical group in Northern California, and Kaiser Foundation Hospitals, Inc.

In 2003, Kaiser made a medical decision to create the a Kidney Transplant Program (“RTC”) within Kaiser and discontinue outsourcing these services to outside hospital programs, mainly to the renal transplant programs at U.C. San Francisco (“UCSF”) and U.C. Davis (“UCD”). The Plan delegated responsibility for program development, administration and oversight of services to the physician officials in The Permanente Medical Group. In mid March of 2006, the Department received a complaint about the transplant program and initiated an investigation into the program’s operation. On May 12, 2006, Kaiser made the decision to phase out its kidney transplant program at the San Francisco Medical Center.

The non-routine survey was conducted to evaluate the adequacy of the Plan’s delegation oversight of important administrative and clinical functions associated with the Renal Transplant Center (“RTC”). These areas included: administrative capacity, continuity of care, grievance and appeals, and availability and accessibility of medically required specialty care in Northern California.

The Department’s survey team conducted extensive interviews with administrative and clinical staff in the kidney transplant program. The survey team included staff from the Department’s Division of Plan Surveys and clinical consultants from the Department’s external contractor, Managed Healthcare Unlimited, Inc. During interviews, other Kaiser staff members attended, including the Director of Regulatory Compliance and regional and national Quality Assurance staff. Kaiser retained the services of private legal counsel who also attended survey interviews.

The Department identified deficiencies in the following areas:

1. Failure to provide oversight of its contracting medical group in the administration of its kidney transplant program.
2. Failure to ensure that its contracting medical group had sufficient administrative capacity to transfer enrollees from externally contracted kidney transplant centers into the medical group’s kidney transplant program.
3. Failure to ensure that it’s contracting medical group consistently provided timely accessibility to medically required specialists in its kidney transplant program.
4. Failure to ensure that its contracting medical group utilized a formal system for handling and processing member grievances.

5. Failure to ensure that specialty services related to kidney transplantation was provided in a manner providing continuity of care and ready referral of patients.

The Preliminary Report of survey findings was sent to the Plan on June 13, 2006. The Plan was required to submit a response to the Preliminary Report within 30 days of receipt of the Preliminary Report. The Plan submitted its response via electronic mail to the Department on July 14, 2006 and via hard copy on July 17, 2006.

The Department notes that the Plan's response focuses solely on the consequences of Kaiser's decision to discontinue the RTC after transfer of Plan members to the wait lists of UCSF or UCD. It does not directly address the deficiencies identified by the Department, which relate to Kaiser's failures in past performance and operation of the kidney transplant program. Nevertheless, despite its failure to directly address these deficiencies, the Plan has attested through a separate document that the information provided in its Response to the Preliminary Report is true and correct to the best of its knowledge.

**A COPY OF THIS REPORT HAS BEEN REFERRED TO THE DEPARTMENT'S
OFFICE OF ENFORCEMENT.**

Survey Results

The table below lists deficiencies identified during the non-routine survey.

#	DEFICIENCIES
PLAN OVERSIGHT	
1	The Plan failed to provide oversight of its contracting medical group in the administration of its Kidney Transplant Program, including administrative capacity and budgetary resources; the Plan's governing body failed to oversee responsibilities performed by its contracting medical group. [1300.70(b)(2)(C), 1300.70(b)(2)(F), 1300.70(b)(2)(G)(1)-(5)]
ADMINISTRATIVE CAPACITY	
2	The Plan did not ensure that its contracting medical group had sufficient administrative capacity to transfer enrollees from externally contracted kidney transplant centers into the medical group's kidney transplant program. [1300.67.3(a)(2), 1367(g)]
ACCESS AND AVAILABILITY	
3	The Plan did not ensure that its contracting medical group consistently provided timely accessibility to medically required specialists in its Northern CA Kidney Transplant Program through staffing, contracting, or referral. [1300.67(d), 1300.67(e), 1300.67(a), 1300.67(a)(1), 1367(d) and (e)(1)]
GRIEVANCES AND APPEALS	
4	The Plan did not ensure that its contracting medical group utilized a formal system for handling and processing member grievances. [1300.68(a), 1300.68(e)(2), 1368(a)]
CONTINUITY OF CARE	
5	The Plan did not ensure that specialty services related to kidney transplantation were provided in a manner providing continuity of care and ready referral of patients. [1367(d), 1300.67.1(e)]

SECTION I: PRELIMINARY REPORT AND PLAN RESPONSE

The Department notified the Plan by letter, dated May 11, 2006, of its intent to conduct a non-routine medical survey, pursuant to California Code of Regulations (CCR) Rule 1300.82.1(a). The non-routine survey was conducted at the Northern California Kidney Transplant Center in San Francisco, California on May 16 and 17, 2006.

The Preliminary Report dated June 13, 2006 served as notice of survey findings and deficiencies identified during the non-routine medical survey of the Plan. In accordance with Section 1300.80.10, the Plan submitted its written response to the Preliminary Report via electronic mail on July 14, 2006. The Plan is being charged for the non-routine survey in accordance with California Health and Safety Code Section 1382(b). This Final Report is based on the Department's review of the Plan's Response to the Preliminary Report and describes the compliance efforts proposed by the Plan and the Department's findings regarding the adequacy of those compliance efforts.

The Plan stated the following in its Response to the Preliminary Report:

“For purposes of this Response, the Plan focuses on demonstrating evidence of compliance and sufficient corrective actions to ensure compliant operation of the Renal Transplant Center (“RTC”) and protecting the care and rights of the RTC’s transplant patients, rather than on addressing the alleged facts recited or implied in the Preliminary Report. Accordingly, this Response does not express concurrence with or admission of the accuracy or completeness of the findings, nor is it an admission or concession on the part of the Plan or its contracted providers of wrongdoing or liability. However, the Plan firmly acknowledges its responsibility to provide and arrange for appropriate clinical and administrative capacity. The Plan also acknowledges that it is responsible for oversight of the RTC and for patient safety, access, and continuity of care for members who need medically necessary transplant services. The Plan’s primary concern has always been, and continues to be, the welfare of members. This Response describes the Plan’s efforts in furtherance of this commitment and its response to the Preliminary Report.

The Plan began offering covered renal transplant services at the Kaiser Foundation Hospitals (“KFH”) facility in San Francisco (“KFH-SF”) in 2004. As the Department is aware, the KFH-SF RTC has confirmed its intentions to voluntarily deactivate the RTC upon the completion of the successful transfer of all Plan members on its United Network for Organ Sharing (“UNOS”) wait list to the wait lists of the renal transplant centers at the University of California at San Francisco Medical Center and University of California at Davis Medical Center. After every member is re-listed through UNOS at UCSF or UCD, with his or her accrued wait time properly transferred, the RTC will cease operations. Until that time, the RTC will operate in accordance with applicable federal, state and UNOS requirements.

Because the RTC will no longer provide transplants after the successful transition of all transplant patients, the Plan's corrective action plan for the deficiencies set forth in the Department's Preliminary Report will focus on the transition plan now currently in place, more fully described below in Section III [Transition Plan, attached to this Report as Appendix E] and Section IV [Plan's response to the deficiencies described in the Preliminary Report, included at Section III of this Final Report] of this Response. The Plan is committed to an effective, patient-centered transition that safeguards the interests and rights of Plan members."

Transition Plan – Member Transfer to UCSF or UCD Renal Transplant Centers

The Plan submitted a detailed narrative description of its plan to transfer transplant members from the wait list of the RTC to the wait lists of the transplant centers at UCSF or UCD. This transition plan was developed under the supervision of the Department, and in collaboration with other state and federal agencies, outside transplant centers, and the United Network for Organ Sharing ("UNOS"). The Plan also submitted a copy of the transition plan (current as of July 11, 2006), which outlines the tasks, accountable individuals, metrics/success criteria, start date, and next steps. The narrative description and transition plan submitted by the Plan are included in Appendix E.

SECTION II: BACKGROUND

UNOS¹ Waiting List

To become a transplant candidate, a patient must be evaluated and accepted by a transplant hospital. This involves completing an evaluation and agreeing to meet any conditions set by the program. It is up to each center to decide whether or not it will accept a patient as a transplant candidate.

The patient is placed on the UNOS waiting list by the transplant center. Once a center accepts a patient as a candidate for transplant, the waiting time begins. According to the UNOS brochure “Questions and Answers for Transplant Candidates and Families about Multiple Listing and Waiting Time Transfer,” waiting time is a more important factor for certain organ types such as kidney and pancreas in matching a patient for an organ offer. Primary waiting time is the longest amount of time a candidate has waited at any center. If a candidate lists at multiple centers, waiting time at each center starts from the date that center listed the candidate. Organ Procurement and Transplantation Network (“OPTN”) policy allows for transfer of primary waiting time to another center where the patient is listed, or switching time waited at different programs.

Transferring waiting time from one transplant center to another must be approved by the transplant center. To end wait time listing at one program and transfer to another, primary waiting time can be transferred as long as it is coordinated with both programs. The new program will usually require the candidate to make a written request to transfer waiting time. Per the brochure, “Keep in mind that if a patient ends a listing at one program before another program formally accepts, a risk of losing all previous waiting time exists.” When a patient moves between centers, the patient must consent and only the receiving unit may execute the transfer. In addition to placing the patient on the UNOS wait list; the receiving center must provide key patient specific demographics, patient history information and clinical outcome data.

Kaiser Kidney Transplant Program

In September 2004, the Plan opened the Northern California Kidney Transplant Program (the “Program”). The Plan stated that during the June 2004 timeframe it began notifying 1500 plus Kaiser members listed and waiting for kidney transplants at UC San Francisco or UC Davis. The notice informed the patients that effective September 1, 2004, current authorizations for kidney transplant services provided by transplant centers external to the Plan would expire and that the cost of any services provided by these facilities after this date would not be paid by the Plan.

One version of a template letter provided by the Plan to the Department indicated that the Program would be contacting the member by mid summer with appropriate forms and an official letter with exact dates for transfer of care. This letter also stated, in boldface type, that “We

¹ The United Network for Organ Sharing (“UNOS”) is a non profit, scientific and educational organization based in Richmond, VA that administers the nation’s Organ Procurement and Transplantation Network.

would like to reassure you that during this transition, you will not lose your place on the kidney transplant waiting list.”

During the period of approximately September 2004 through January 1, 2005, the Program’s Data Manager entered patient data (for those members who returned the UNOS Wait Time Transfer Form) into the UNOS system’s Active Master List, a secure Web-based computer system. The UNOS system maintains the national organ transplant waiting list and recipient/donor organ characteristics.

At some point, according to one Kaiser Program staff member, in early 2005, Kaiser became aware that a problem existed with transferring transplant candidates from the external centers into the Kaiser Program. UNOS informed Kaiser that information entered (by the Program) was wrong. Kaiser staff informed the Medical Director of frequent emails and calls from transplant candidates about their transfer status. However, many of the calls went unanswered. Kaiser reported they made attempts to contact UNOS to find out why the remainder of the transfers had not occurred, but were unsuccessful. As a result, the Medical Director “stepped forward” with UNOS and “yelled at them” and they got another UNOS coordinator. After that, things got faster.

SECTION III: DEFICIENCIES IDENTIFIED

Deficiency #1: **The Plan failed to provide oversight of its contracting medical group in the administration of its Kidney Transplant Program, including administrative capacity and budgetary resources; the Plan’s governing body failed to oversee responsibilities performed by its contracting medical group. [1300.70(b)(2)(C), 1300.70(b)(2)(F), 1300.70(b)(2)(G)(1)-(5)]**

Documents Reviewed:

All documents described in Deficiencies 2 through 4

Department Findings:

- The Department found no evidence the Plan was aware of or involved with planning and effectuating the transfer of more than 1500 members from external transplant programs into the Program. This function was administered through the Permanente Medical Group Transplant Program.
- Requests to replace program staff were denied. These requests were routed through the Administration service line and included those who left the Program or transferred outside of Kaiser.
- The Office Manager stated she received complaints from Program staff that they didn’t feel any connection to the bigger Kaiser picture, that they felt like they were in a “cocoon” and that she was “shocked that the Kaiser folks had no clue regarding what was happening.”

Implications: It is the duty of the Plan to oversee and monitor any functions, administrative or clinical, delegated to another contracted or affiliated service entity. In this case, the Plan

delegated to the Permanente Medical Group the responsibility for administrative, clinical and programmatic functions in developing and implementing a new kidney transplant program.

In doing so, the Plan delegated a significant degree of responsibility and patient risk to the medical group. Due to the heightened complexity and potential risk to kidney patients, only through close oversight can the Plan ensure that the delegated agent provides the service and quality of care as is required of the Plan. This is critical in order to ensure patients are safely and effectively treated by the delegated entity. The Plan's oversight is critical and codified in the Act and its implementing regulations.

The remainder of this Preliminary Report further describes the supporting evidence for this deficiency.

Plan's Response to Preliminary Report: The Plan stated that the transition plan sets forth a detailed plan of action that effectuates the Plan's obligation to oversee the renal transplant program in its transition. This transition plan has been developed and coordinated by representatives of the Plan, the RTC, and the Permanente Medical Group ("TPMG"). The RTC and the Plan have maintained and shall continue to maintain a detailed action log that lists the steps needed to complete the transfer of patients to UCD and UCSF. This log includes identifying the party responsible for completing each step, plus a due date for completion of the step. The Plan submitted a copy of the current action log with its Response.

The Plan, the RTC, and TPMG representatives have been meeting at least weekly with the Department, UCD, UCSF and UNOS and will continue to do so until all patients have been transferred. Through this transition process, the Plan receives daily feedback from the RTC and TPMG about the status of the transition and can immediately address and timely resolve issues that may impact the orderly transfer of patients to UCD and UCSF.

In addition, oversight of the RTC's transplant program is being accomplished through the following:

- The RTC's Governing Body Advisory Committee is responsible for using the Quality program indicators to ensure that the transplant program has the capacity and capability to meet the needs of the RTC patient population, including access to organs, credit for wait time, prompt evaluation and integration of care with the contracted transplant facilities. The Governing Body Advisory Committee includes the RTC Medical Director, the RTC Chief Executive Officer ("CEO"), the RTC Surgical Director, a dietitian, the KFH-SF Chief of Staff and others.
- The RTC CEO will submit a report to the Area Manager on at least a monthly basis through the RTC Governing Body Advisory Committee and the KFH-SF professional staff Quality Utilization and Oversight Committee.
- The Plan's Northern California Region Quality Oversight Committee exercises oversight of the RTC quality improvement process by requiring regular reports from the Area Manager. Reports will be required no less than quarterly to ensure program capacity and effectiveness.
- Monitoring of the transplant process occurs through:

1. Weekly reports of progress on transition plan implementation during meetings with the Department, the RTC and the contracted transplant centers
2. Daily reports of patient records transferred to the transplant centers
3. 100% concurrent monitoring of the transition of each patient by the Compliance Officer/Designee
4. Audits of compliance with UNOS Wait List Policies by the Compliance Officer/Designee on a monthly basis
5. 100% review of organ disposition log on a weekly basis by the RTC's Medical Director, with monthly reports to the Area Manager

Department's Finding Concerning Plan's Compliance Effort: The Department notes that the Plan's response focuses solely on the consequences of Kaiser's decision to discontinue the RTC after transfer of Plan members to the wait lists of UCSF or UCD. It does not directly address the deficiencies identified by the Department, which relate to Kaiser's failures in past performance and operation of the kidney transplant program. Nevertheless, despite its failure to directly address these deficiencies, the Plan has attested through a separate document that the information provided in its Response to the Preliminary Report is true and correct to the best of its knowledge. The Plan's current activities are in stark contrast to its abdication of responsibility, which it neither addresses nor contests, to provide oversight of the transfer of patients to the RTC and the administration of the program during its operation.

Deficiency #2: **The Plan did not ensure that its contracting medical group had sufficient administrative capacity to transfer enrollees from externally contracted kidney transplant centers into the medical group's kidney transplant program. [1300.67.3(a)(2), 1367(g)]**

Documents Reviewed:

- Organizational Chart entitled "Transplant Services KPMC-SF," dated May 2006
- Current and Past Staff of the Transplant Department, Date of Report: 5/12/06
- Kaiser Permanente Medical Center – Core Staffing, ESRD/Transplant Services (no date)
- UNOS Application with cover letter dated March 28, 2003 signed by Arturo Martinez, MD, FACS and Sharon Inokuchi, MD, PharmD
- "Kaiser Permanente-San Francisco Transplant Program Fact Sheet," no date

Department Findings:

Lack of Effective Management:

- Due to staff turnover, the Program has had three Administrative Directors, with up to twenty staff members reporting to him/her. One of the three Directors was a registered nurse ("RN"). The second Director was employed for seven weeks. The current Director has held the position for three months, beginning March 2006. Through time, seven RN Transplant Coordinators were hired with no supervisor. In practice, despite the existence of an Administrative Director position and lack of an RN supervisor, staff indicated that they reported directly to the Program's Medical Director.

- According to the Office Manager, there were staffing issues “from the beginning.” Administration denied requests to replace positions due to staff resignations or transfers. Several staff members indicated that in addition to administrative staff, physicians also completed waiting list transfer forms.
- Policies and procedures submitted to the Department described how staff effectuated the patient transfer process; however, they were inadequate in providing specifics about how staff were to perform their jobs. This issue is described more fully under Deficiency #5.
- The Data Manager worked an estimated 10 to 16 hours per day during the 4-month transition of transplant candidates, transferring from the outside centers into the Kaiser Program. This included the relay of patient demographic and clinical data into the UNOS system. When assistance was requested, the Program Medical Director denied the request because she didn’t want to disturb the integrity of the data. The Department could not determine the existence of internal processes to validate the accuracy or quality of the data entry. This issue is described more fully under Deficiency #5.
- To determine the number and types of staff at different points in time during the Program’s operation, the Department repeatedly requested basic information about staffing in advance of the survey, including an organizational chart for the Program showing number of positions, titles, reporting lines and a listing of staff dedicated to the Program.
- The organizational chart was created while the Department was on-site. The staff listings provided to the Department, however, are contradictory. For example, a document entitled “Current and Past Staff of the Transplant Department” dated 5/12/06 shows three Licensed Clinical Social Workers and/or Medical Social Workers, while a document titled “Kaiser Permanente Medical Center – Core Staffing, ESRD/Transplant Services” shows only .8 of a full time employee allocated to Inpatient Licensed Clinical Social Worker Case Management.
- The majority of Program staff (including RN’s) had no prior renal/transplant experience. The Program Medical Director trained the nursing staff and social workers. The Program’s administrative support person, who was new to the Program, sent “meet and greet” letters to members transferring to the Program; however, according to the Office Manager, struggled with basic clerical skills.
- One Pre-Transplant Coordinator was on staff between 9/04 and 12/04, when 1500 plus patients were in the active transfer process from outside centers. It was reported the Coordinator was in training the majority of this time.

Lack of Planning for Transition of Members from External Transplant Waiting Lists:

The lack of planning for transitioning the 1500 plus existing transplant patients residing on external waiting lists resulted in untimely access/ delays to kidney transplant services.

- On March 28, 2003, the Kaiser program submitted an application to UNOS for institutional membership as a Clinical Transplant Center. This included a program implementation plan. The Implementation Plan outline, approximately one and one-half pages in length, consists of two parts: 1) a timeline outlining tasks in bullet format from 2002 through 2nd quarter 2004 and 2) a narrative Implementation Summary.

The timeline projected approximately five to ten living donor transplants during 4th Quarter 2003 and approximately ten to 20 cadaver transplants by mid-year 2004. There is no description in the Implementation Plan, nor in any other document provided to the Department, of the resources, staff, or any of the myriad of activities that would be required to transfer the 1500 plus transplant candidates from external transplant programs into the Program or how medically necessary services were to be provided to them.

The second page of the Implementation Plan states the Program expected growth of 100 transplants per year, but does not describe in any way the transfer of patients from other transplant centers and only describes evaluations for new patients, which were to begin in the third quarter of 2003.

The plan references one administrative support position required to implement the Program, personnel responsible for data collection and submission. The application asks for a listing of the personnel who will be responsible for data collection and submission, their background, and percent of time allocated to data collection and submission, also indicating that additional pages should be used as needed. The Program listed a single individual, at 100% time, and a brief paragraph of her background (no degrees listed, no clinical background); however, extensive experience in data collection/extraction, “having served as the primary research coordinator for all the clinical research conducted by Dr. Inokuchi at CPMC.”

- In response to a request for information re: kidney transplant services by Tom Gilevich, Staff Counsel with the HMO Help Center, to Dan Chesir, March 27, 2006, the Plan’s Health Plan Regulatory Services Division submitted a document entitled “Kaiser Permanente – San Francisco Kidney Transplant Program Fact Sheet.” his document shows the number of transplants performed for the years between 2000 and 2006 (estimated) by Kaiser and UCSF. It states that the “volume of transplants is closely linked to the transition from UCSF to KPSF” and 2005 as the year that “KP starts up with planned decline in volume.” Although reduced capacity was contemplated, there was no plan for providing access to treatment for individuals transferred in excess of the Program’s capacity to provide transplants.
- On the surface, the Fact Sheet document looks to be a planning document, and indeed is the only document provided to the Department that shows projected number of transplants based on the transfer of 1500 plus members or shows any kind of planning for the transfer of these patients into the Program. The document, however, is not dated or identified in any way, such as part of a planning document or implementation plan or approved in committee minutes. The Department, therefore, concludes that it was produced specifically for the purpose of responding to Tom Gilevich’s request for information of March 27, 2006.

- The lack of adequate transition planning is apparent from the inception of the program and subsequently. The Department asked the Plan when they became aware of the 1500 plus members on the external waiting lists, waiting to be transferred to the Program. The Data Manager stated, "Once they started coming." Yet no document was provided which addresses how the Plan contemplated providing access to necessary medical services for those 1500 members.

Implications: The lack of effective planning by the Medical Group and Plan, evidenced by the absence of a comprehensive Program plan, placed Kaiser patients at risk for disruption in care and potentially life threatening delays in care. The lack of coordination in confirming waiting list placements and accrued wait list times between the transplant programs caused by a lack of planning and adequate numbers of experienced staff, created an unreasonable risk to the patient's ability to obtain a life saving kidney transplant in accordance with accrued wait time list rankings.

Plan's Response to Preliminary Report: The Plan stated that to resolve this deficiency and to comply with Centers for Medicare & Medicaid Services ("CMS") requirements, the administrative structure of the renal transplant center has been expanded to provide greater administrative capacity. On June 21, 2006, the KFH Board of Directors appointed the Senior Vice President/Area Manager ("Area Manager") to serve as the "governing body" of the RTC. The Area Manager is also an officer of the Plan. The Area Manager has full legal authority and responsibility for RTC operations.

On June 21, 2006, the Area Manager appointed a CEO who is now responsible for the day-to-day management and administration of the RTC. The CEO is directly accountable to the Area Manager. She also works collaboratively with the RTC Medical Director to implement the transition plan. Since her appointment, the CEO has attended the weekly meetings with the Department, DHS, UCSF, UCD, and UNOS. The CEO also sits on the RTC Governing Body Advisory Committee, which advises the Area Manager in his role as governing body of the RTC. The CEO provides monthly status reports of the transition plan to the Area Manager. In addition, the CEO has employed additional qualified employees to adequately support the transplant transition plan and has ensured that they have received appropriate orientation for their roles and responsibilities. The Plan submitted a copy of the RTC organization chart with its Response.

Department's Finding Concerning Plan's Compliance Effort: The Department notes that the Plan's response focuses solely on the consequences of Kaiser's decision to discontinue the RTC after transfer of Plan members to the wait lists of UCSF or UCD. It does not directly address the deficiencies identified by the Department, which relate to Kaiser's failures in past performance and operation of the kidney transplant program. Nevertheless, despite its failure to directly address these deficiencies, the Plan has attested through a separate document that the information provided in its Response to the Preliminary Report is true and correct to the best of its knowledge. The Plan's current activities are in stark contrast to its abdication of responsibility, which it neither addresses nor contests, to provide oversight of the transfer of patients to the RTC and the administration of the program during its operation.

Deficiency #3: **The Plan did not ensure that its contracting medical group consistently provided timely accessibility to medically required specialists in its Northern CA Kidney Transplant Program through staffing, contracting, or referral.** [1300.67(d), 1300.67(e), 1300.67(a), 1300.67(a)(1), 1367(d)]

Documents Reviewed:

- “Kaiser Permanente-San Francisco Transplant Program Fact Sheet,” undated
- “DMHC Responses from Dr. Sharon Inokuchi”

Department Findings: In 2004 UCSF performed 136 transplants on Kaiser patients (with 6 at Kaiser); by 2005, first full year of the program’s operation, only 56 transplants were done by the Kaiser program (ten at UCSF). In the “Fact Sheet,” the Program states that 100 transplants per year represents a “steady state” and was the total number estimated to be performed in 2006. However, the data presented by the Program do not provide convincing support for this statement, because 138 and 142 transplants were performed on Kaiser members by UCSF in 2003 and 2004 respectively. However, even if 100 transplants annually were assumed to be “steady state,” in 2005 only 66 were performed, suggesting a very high likelihood that access to Kaiser transplant services was significantly delayed.

Implications: It is the responsibility of the Plan to ensure patients have access to the right care at the right time. In failing to ensure the medical group provided appropriate and timely specialty care, and in failing to monitor services provided to kidney patients through the group in order to identify problems quickly and early, the Plan breached a duty to Kaiser patients by not ensuring the provision of the basic health care services required under benefit contracts and the law.

Plan’s Response to Preliminary Report: The Plan stated that Plan members will continue to have access to their Plan nephrologists during and after the transition period. The Plan provided a blanket authorization for medically necessary transplants for all members who elect to have their transplants performed at UCD or UCSF as an initial and essential part of the transition plan. Such authorization grants access to covered transplant services for members, including access to medical specialists connected with such transplants. Members may see the transplant surgeons at UCD and UCSF for covered specialty services associated with their transplants.

Department’s Finding Concerning Plan’s Compliance Effort: The Department notes that the Plan’s response focuses solely on the consequences of Kaiser’s decision to discontinue the RTC after transfer of Plan members to the wait lists of UCSF or UCD. It does not directly address the deficiencies identified by the Department, which relate to Kaiser’s failures in past performance and operation of the kidney transplant program. Nevertheless, despite its failure to directly address these deficiencies, the Plan has attested through a separate document that the information provided in its Response to the Preliminary Report is true and correct to the best of its knowledge. The Plan’s current activities are in stark contrast to its abdication of responsibility, which it neither addresses nor contests, to provide oversight of the transfer of patients to the RTC and the administration of the program during its operation.

Deficiency #4: **The Plan did not ensure that its contracting medical group utilized a formal system for handling and processing member grievances.**
[1300.68(a), 1300.68(e)(2)]

Department Findings: During staff interviews, several staff members reported receipt of consumer complaints from patients dissatisfied with the transfer to the Kaiser Program. The Pre-Transplant Case Manager stated that she handled and investigated patient complaints. She discussed the issue with the Medical Director and Administrative Director and responded to the patient verbally or in writing.

However, the Department was not provided with grievance logs or acknowledgement and resolution letters. There was no evidence to demonstrate member complaints were tracked or logged. According to staff interviewed minimal coordination between the Program and Member Services at the Plan level existed on member grievances and complaints.

The Department's HMO Help Center is conducting further analysis of complaints made by members regarding the Plan's Program. Those findings may be reported separately outside the scope of this report.

Implications: Due to lack of Plan oversight, patient grievances and complaints were not acknowledged, resolved or tracked in accordance with regulatory requirements, nor were they reported or evaluated by the Plan. The Medical Group resolution process denied the enrollee the basic protections of appeal and access to the Department as is required under the Act. The Plan's failure to inquire as to the handling of complaints and grievances, or request a report to assess the level of patient satisfaction with the services further demonstrates the Plan's lack of adequate oversight of the Medical Group administration processes.

Plan's Response to Preliminary Report: The Plan stated that the RTC has developed and implemented a complaint/grievance process specific to issues related to transplants. The Plan submitted a copy of the RTC policy "Transplant Related Complaints/Grievances" with its Response. This policy applies to member grievances and complaints related to transplant services, regardless of where in the Plan's Northern California Region the complaint/grievance is received. Member complaints and grievances involving patients referred for evaluation as a transplant candidate will be sent to KFH-SF's Department of Patient Safety/Risk Management for screening and, where applicable, clinical review.

Given the circumstances related to suspension of the RTC, the RTC and Plan jointly decided that all cases requiring clinical review for quality of care concerns or clinical eligibility determinations will be triaged to a contracted third party clinical reviewer consisting of transplant surgeons and/or transplant nephrologists. This review will be coordinated by KFH-SF's Department of Patient Safety/Risk Management. Outcomes of clinical reviews will be forwarded to Member Services department at the facility managing the complaint. Outcomes of quality assurance/peer review will be forwarded to the appropriate Quality Department. This additional review by a third party is limited to kidney transplant related complaints and grievances related to or occurring during the transition of services to UCD and UCSF.

In addition to the policy and procedure described above, the Plan collects and/or requires the RTC to collect data related to patient complaints, grievances, and appeals, as well as member satisfaction with transplant services and the transition plan. This data will be reported on a monthly basis to the RTC Governing Body Advisory Committee and to the KFH-SF professional staff Quality Utilization and Oversight Committee (QUOC). On a quarterly basis, the outcomes will be reported by the Area Manager to the Plan through the Plan's Northern California Region's Quality Oversight Committee, which ultimately reports to the Plan's Board of Directors.

In order to handle increased calls related to renal transplant services and the transition plan, on May 13, 2006 the Plan instituted an additional toll-free Member Services Call Center number dedicated to handling inquiries, complaints and grievances related to the RTC. The Call Center staff was provided with scripts that were reviewed and approved by the Department prior to implementation. Once the dedicated toll-free line was instituted, the Plan added additional staff to ensure that all member questions, complaints and grievances would be addressed in a timely manner.

Department's Finding Concerning Plan's Compliance Effort: The Department notes that the Plan's response focuses solely on the consequences of Kaiser's decision to discontinue the RTC after transfer of Plan members to the wait lists of UCSF or UCD. It does not directly address the deficiencies identified by the Department, which relate to Kaiser's failures in past performance and operation of the kidney transplant program. Nevertheless, despite its failure to directly address these deficiencies, the Plan has attested through a separate document that the information provided in its Response to the Preliminary Report is true and correct to the best of its knowledge. The Plan's current activities are in stark contrast to its abdication of responsibility, which it neither addresses nor contests, to provide oversight of the transfer of patients to the RTC and the administration of the program during its operation.

Deficiency #5: **The Plan did not ensure that specialty services related to kidney transplantation were provided in a manner providing continuity of care and ready referral of patients.** [1367(d), 1300.67.1(e)]

Documents Reviewed:

- Letter dated 10/22/03, unsigned template
- Letter dated 12/16/03, addressed to "Dear Member," signed
- Letter dated 3/17/04, unsigned template
- Letter dated 6/22/04, unsigned template
- Letter dated 6/23/04, unsigned template
- Letter dated 7/23/04, addressed to "Dear Member," signed
- Letter dated 7/27/04, addressed to "Dear Member," signed
- "UNOS Wait Time Transfer Form"

Department Findings:

- Medical records: The Program sent a copying service on two occasions to copy medical records at UCSF; however, according to the Medical Director, not all medical records were obtained. The Pre-Transplant Coordinator stated "those medical records were not available

to us not because we didn't try . . . UCSF treats this [preparing patients' medical records] as a very big job." She also stated that at one point there was confusion as to what was required to obtain the record, with UCSF stating that the patient had to sign a release of information. At other points it was her understanding that as a contracted facility, access to the medical records was allowed through the provider contract without having every patient agree in writing to release of medical records.

- Patient notifications: Staff members interviewed by the Department indicated that several mailings were sent to the 1500 plus members affected by the transfer of kidney transplant services to Kaiser. The Pre-Transplant Coordinator indicated that the mailing included a letter explaining the transfer, the wait time transfer form, and a self-addressed envelope.

When asked about the origin of the list used to identify the members for notification, several staff interviewed by the Department indicated that they did not know. The Pre-Transplant Coordinator stated that she assumed that "the demographics came from Kaiser regional and UCSF."

After making multiple requests for samples of actual letters sent to members both prior to and during the survey, the Program provided seven copies of letters to the Department at the end of the last day of the survey. All were initial notification letters; none were related to list placement or how patients wait time would be transferred, with the exception of one which was dated July 23, 2004 that stated "We would like to reassure you that during this transition, you will not lose your place on the kidney transplant waiting list."

There were several versions of the letters. One version, dated June 22, 2004, essentially notified the patient that effective September 1, 2004, prior authorization for services at UCSF would expire and the cost of any services provided by these facilities after this date would be the patient's responsibility. The letter also provided the address and telephone number for questions or concerns. Despite the fact that the letter constituted modification of an authorization for medically necessary services, the letter did not include member appeal rights or instruct the member on how to file an appeal. Two of the letters reviewed, dated June 22, 2004 and June 23, 2004, stated that effective September 1, 2004, the Program would "begin providing you with your transplant care . . . ***Pending Federal Regulatory Approval.***" (Emphasis added).

The Department raises concerns regarding whether appropriate providers at UCSF and UCD were notified that their patients were being transferred to another program. The Department also questions whether the Program could identify the patient's UCSF/UCD physician or which transplant center they were being transferred from.

It is standard business practice to specify on a cc: specific information about who is receiving a copy of the letter, for example, a contact name and address. However, the cc:'s on the letters reviewed by the Department read "UCSF medical (sic)," "Nephrologists, UCSF Transplant Program, UCD Transplant Program," "Kaiser Permanente Nephrologists, University of California, San Francisco Medical Center, University of California, David Medical center (sic), Stanford University Medical center (sic)," and "Referring Nephrologist, Non-Kaiser Transplant Program." These were the only documents provided to the

Department in its attempt to determine what notifications members received regarding the transfer of their care, the Program was not able to demonstrate that the appropriate providers were notified of the transition of care or even that the Program knew who the patient's providers were.

Four of the seven letters appear to be templates, as they do not contain an actual signature and are addressed to "Jane Doe" or "John Doe." The other three letters appear to be copies of actual letters, with signatures by the Medical Director, Surgical Transplant Director and/or Administrative Director. These letters are addressed "Dear Member," which suggests to the Department the specific patient was not identified.

- Wait Time Transfer Form: The "UNOS Wait Time Transfer Form" was sent by the Program to transplant candidates to formally request that the patient's waiting time be transferred to the Program. Staff stated after multiple mailings, they estimated that they received 90% of the patient transfer forms but could not verify what happened to the remaining 10%.

The transfer form does not provide direction to the patient about how to complete the form or direct the patient once the form is complete. The following examples are illustrative:

- The form states at the top: "Please add patient to new list prior to faxing this form to UNOS", while in small type at the bottom it provides a fax # and contact name, both of which are UNOS contacts. However, the form was supposed to be sent to the Program and the Pre-Transplant coordinator, not UNOS. Staff stated that there were "innumerable people who over a long period of time (said) I've signed that form four times." The Program continuously advised these members that the form had not been received and to re-fax or send by US mail.
- The form states that the member wishes to transfer waiting time from UCSF to "my new listing at KP San Francisco" but then goes on to require the patient to indicate their choice of listings. According to staff interviewed, patients who checked both boxes completed the form incorrectly thereby delaying the processing of their transfer into the Program. The Pre-Transplant Coordinator stated that the list placement choice was confusing to patients because they didn't understand that there was only one list, but wanted their name on any and all lists.
- The two choices were:
 - Wish to be removed from the transplant candidate list at: (CASF) – UC San Francisco and wish to be listed as a transplant candidate ONLY at: (CAKP) – KP San Francisco, or
 - Do NOT wish to be removed from the transplant candidate list at:
I wish to continue to be listed at both transplant centers.

The Pre-Transplant Coordinator stated that they were told by UNOS at one point that they could not accept fax forms because they needed an original patient signature on the transfer form. The lack of clarity regarding the proper procedure for submitting wait time transfer data to UNOS was a significant factor in delaying member's access to kidney transplant services.

The Data Manager, when asked if there was one thing that could have been done differently, stated that they should have talked with UNOS “before all this happened . . . (regarding) the best way to transition patients in an orderly manner.”

- Lack of adequate policies and procedures. Policies and procedures submitted to the Department were not adequate to provide staff with direction about how to do their jobs. The one page policy titled “UNOS Candidate Listing for Kidney Transplantation” effective 2004 states at the bottom of the page:

TRANSFER WAITING TIME TO CAKP

1. Patient must have signed UNOS waiting time transfer form
2. UNOS signed forms are FAXED to UNOS
3. FAX face sheets

The policy entitled “Kidney Transplant Program: Transplant Candidates with Waiting Time,” also one page and effective 2004, consists of two parts: Introduction, which states that “Transfer will be in accordance to policies set by UNOS for such transfers between waiting lists, and no patient will suffer a disadvantage in waiting time or access to kidney transplantation during the process” and Objectives which state that adequate staffing will be available.

No evidence was offered to demonstrate a process to verify the accuracy or quality of the demographic and clinical data entered into the UNOS system. The Data Manager could not confirm the data she entered was verified for accuracy or whether UNOS was to confirm the transfer. As a result she reviewed each record, confirming one by one the transfer had occurred. She had no procedure or checklist to follow. She stated that the Pre-Transplant RN should have followed up with transfers on problem cases, for example, to ensure forms were returned or verify the status of specific patients’ list number. However, this did not happen. The Data Manager attempted to process 100 patients per day, both new and transfers, which required completion of two forms for each patient. She also stated that the Pre-Transplant RN received calls from patients regarding frustrations with the process.

Implications: The Program failures in securing and relaying accurate patient information and failing to coordinate with treating physicians and UNOS, presented the greatest risk to the Kaiser transplant patients because it created a “limbo” status whereby the patient’s wait listing status was unknown for an indefinite period of time. The Plan’s failure to ensure appropriate patient support with the UNOS Transfer form caused referral delays and hindered continuity of care.

The Plan demonstrated no evidence of an effective oversight of the Program and unfortunately, the problems this created would be experienced into the future.

Plan’s Response to Preliminary Report: The Plan stated that the transition plan, coordinated by the Plan, the RTC, and TPMG expressly includes a blanket authorization for referrals to UCD or UCSF, at the member’s preference, for medically necessary transplants. Members also continue to receive services from their Plan nephrologists, who will cooperate with UCD and UCSF to coordinate care as necessary, providing continuity of care for these members. As stated

above in the response to Deficiency #3, authorization of transplants at UCD or UCSF shall include access to the medical specialists connected with such transplants. Thus, the transition plan incorporates the Plan's obligation to provide continuity of care and ready referrals of members for covered transplant services at UCD and UCSF and prompt availability of medical records pursuant to a coordinated transfer of copies of medical records.

Department's Finding Concerning Plan's Compliance Effort: The Department notes that the Plan's response focuses solely on the consequences of Kaiser's decision to discontinue the RTC after transfer of Plan members to the wait lists of UCSF or UCD. It does not directly address the deficiencies identified by the Department, which relate to Kaiser's failures in past performance and operation of the kidney transplant program. Nevertheless, despite its failure to directly address these deficiencies, the Plan has attested through a separate document that the information provided in its Response to the Preliminary Report is true and correct to the best of its knowledge. The Plan's current activities are in stark contrast to its abdication of responsibility, which it neither addresses nor contests, to provide oversight of the transfer of patients to the RTC and the administration of the program during its operation.

IV. SURVEY CONCLUSION

The Department has completed a non-routine survey of Kaiser's delegated oversight of the Northern California Kidney Transplant Program. The Department continues to work with Kaiser to ensure that all new and existing kidney transplant patients are transferred safely to other programs and understands Kaiser's decision to discontinue kidney transplant services indefinitely. We would emphasize, however, the importance of Plan oversight when delegating any administrative, clinical or programmatic function and the requirements inherent in the Act are binding upon the Plan.

A P P E N D I X A

A. THE REPORTING PROCESS

Preliminary Report

Within 60-80 days of the on-site visit, the Department provides the plan with a Preliminary Report, which details deficiencies and survey findings. Preliminary and Final Reports are deficiency and finding-based reports; therefore, only specific areas found by the Department to be deficient or of concern are included in these reports. Omission of other areas of the plan's performance from the reports does not necessarily mean that the plan is in compliance with the Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the plan's performance in other areas.

Plan's Response to the Preliminary Report

All deficiencies cited in the Preliminary Report require corrective actions by the plan. Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency. For those deficiencies that may reasonably be expected to require a longer period than 30 days to remedy, a plan may submit evidence that the plan has initiated remedial action to achieve an acceptable level of compliance.

The plan's response should include the following information for each deficiency identified in the Preliminary Report:

- (1) The plan's response to the Department's identified deficiencies, including a corrective action plan;
- (2) If the corrective action plan is fully implemented, the plan should provide evidence that the deficiencies have been corrected;
- (3) If the corrective action plan cannot be fully implemented by the time the plan submits its response, the plan should submit evidence that remedial action has been initiated and is on the way to achieving acceptable levels of compliance. Include a time schedule for implementing the corrective action and a full description of the evidence the plan will submit for the Department's Follow-Up Review that will demonstrate the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the plan's response indicates that the development and implementation of corrective actions will not be completed by the time the plan files its response, the plan should file any policies and procedures required for implementation as plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the plan should file both a clean and redline version of revised policies and procedures

through the Department's web portal. The plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review and consideration of the plan's response to the Preliminary Report, the Department will issue a Final Report. The Final Report will first be issued to the plan, followed by a copy to the public file. The report is available to the public by mail or on the Department website at: http://www.dmh.ca.gov/library/reports/med_survey.

The Final Report will contain the deficiencies and findings as they were reported in the Preliminary Report, a summary of the plan's response and the Department's determination concerning the adequacy of the plan's response. The plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Reports on all surveys, deficiencies and correction plans shall be open to public inspection after the Plan is given an opportunity to review the report and respond within 45 days of the date the Plan received the report from the Department. A Final Report will be issued after review of the Plan's response and will exclude any survey information and legal findings and conclusions determined by the Director to be in error, describes compliance efforts, identifies corrected deficiencies and describes remedial actions for deficiencies requiring longer periods to remedy. (Section 1380(h)(2)).

At the same time the Department makes the Final Report available to the public, a summary of the report will be issued to the public file. One copy of the summary is available free of charge to the public by mail. Additional copies of the summary and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The plan may submit additional responses to the Final and Summary Reports any time before or after the reports are issued.

A P P E N D I X B

B. SURVEY TEAM, PLAN STAFF INTERVIEWED, PROVIDERS INTERVIEWED

The Department's Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Ann Vuletich, M.P.H.	Staff Health Plan Analyst – Team Leader
Roxann Floyd	Staff Health Plan Analyst
Dan McCord, M.B.A.	Senior Health Plan Analyst
Allison Kregness, R.N.	Managed Healthcare Unlimited, Inc. Clinical Consultant
Rose Leidl, R.N.	Managed Healthcare Unlimited, Inc. Clinical Consultant

The following are the key Plan officers and staff who were interviewed during the on-site survey.

NAME	OFFICIAL TITLE/WORKING TITLE
Bernadine Hall-Evans	Administrative Specialist 4/Office Manager
Laura De Belen	Research Associate 2/Data Manager
Mary-Pat Sherman, R.N.	Patient Care Coordinator/Pre-Transplant Nurse Coordinator
Diana Lopez	Service Director/Administrative Director
Nancy Langholff	Assistant Medical Group Administrator
Bonnie Jacobson	Case Manager – LCSW
Sharon Inokuchi, M.D., Pharm.D.	Medical Director, Department of Transplantation

A P P E N D I X C

C. APPLICABLE STATUTES AND REGULATIONS

The following are the specific citations used in this report as the basis for the deficiencies.

PLAN OVERSIGHT

Deficiency #1: **The Plan failed to provide oversight of its contracting medical group in the administration of its Kidney Transplant Program, including administrative capacity and budgetary resources; the Plan's governing body failed to oversee responsibilities performed by its contracting medical group. [1300.70(b)(2)(C), 1300.70(b)(2)(F), 1300.70(b)(2)(G)(1)-(5)]**

Citations:

28 CCR 1300.70 (b)(2)(C)

The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components, which the QA program has identified as presenting significant or chronic quality of care issues.

28 CCR 1300.70 (b)(2)(F)

There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.

28 CCR 1300.70(b)(2)(G)(1)-(5)

Medical groups or other provider entities may have active quality assurance programs, which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

- (1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.
- (2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
- (3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.
- (4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be ensured of the entity's continued adherence to these standards.
- (5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

ADMINISTRATIVE CAPACITY

Deficiency #2: **The Plan did not ensure that its contracting medical group had sufficient administrative capacity to transfer enrollees from externally contracted kidney transplant centers into the medical group's kidney transplant program. [1367(g), 1300.67.3(a)(2)]**

Citations:

Section 1367(g)

The Plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that qualified medical providers, unhindered by fiscal and administrative management, render medical decisions.

28 CCR 1300.67.3(a)(2)&(3)

The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include:

- (2) Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business, and
- (3) Written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective controls.

ACCESS AND AVAILABILITY

Deficiency #3: **The Plan did not ensure that its contracting medical group consistently provided timely accessibility to medically required specialists in its Northern CA Kidney Transplant Program through staffing, contracting, or referral. [1367(d), 1300.67(d) and (e)(1), 1300.67(e), 1300.67(a), 1300.67(a)(1)]**

Citations:

Section 1367(d)&(e)(1)

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e)(1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

28 CCR 1300.67(a), (a)(1), (d) and (e):

(a) Physician services, which shall be provided by physicians licensed to practice medicine or osteopathy in accordance with applicable California law. There shall also be provided consultation with and referral by physicians to other physicians.

(1) The plan may also include, when provided by the plan, consultation and referral (physician or, if permitted by law, patient initiated) to other health professionals who are defined as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably ensure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees.

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral.

GRIEVANCE AND APPEALS

Deficiency #4: **The Plan did not ensure that its contracting medical group utilized a formal system for handling and processing member grievances.**
[1368(a), 1300.68(a), 1300.68(e)]

Citations:

1368(a)

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted

(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.

(4)(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.

(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

1300.68(a)

The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system . . .

1300.68(e)

The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:

(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other

contracts. The system shall indicate whether an enrollee grievance is pending at: 1) the plan's internal grievance system; 2) the Department's consumer complaint process; 3) the Department's Independent Medical Review system; 4) an action filed or before a trial or appellate court; or 5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: 1) the Medicare review and appeal system; 2) the Medi-Cal fair hearing process; or 3) arbitration.

(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as 1) coverage disputes, 2) disputes involving medical necessity, 3) complaints about the quality of care and 4) complaints about access to care (including complaints about the waiting time for appointments), and 5) complaints about the quality of service, and 6) other issues.

CONTINUITY OF CARE

Deficiency #5: The Plan did not ensure that specialty services related to kidney transplantation were provided in a manner providing continuity of care and ready referral of patients. [1367(d), 1300.67.1(e)]

Citations:

1367(d)

A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

28 CCR 1300.67.1(e)

(e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

A P P E N D I X D

D. PLAN'S CLARIFICATION OF UNOS WAIT LIST PROCESS

The Plan stated the following in its Response regarding the UNOS wait list process:

The Plan would like to describe more fully the UNOS wait list process, including how wait times are initially determined and how they are transferred to different facilities. The Plan believes it is important to understand the respective roles of both UNOS and a transplant center in determining wait times for transplant patients.

UNOS Wait List Process²

The allocation of donated, cadaveric organs is handled through a national system, the Organ Procurement and Transplantation Network ("OPTN"), administered by UNOS, as established by federal law. A potential kidney recipient is registered on the UNOS wait list by his or her transplant program. The wait list is for organs from deceased donors only. To be added to the list, a patient must be evaluated by a transplant center, which runs a number of tests and considers the patient's mental and physical health, as well as his or her social support system. If the center determines that the patient is a transplant candidate, it will add the patient's medical profile (which includes demographic and clinical data) to the national patient wait list for organ transplant. The patient is *not* placed on a ranked list at that time. Rather, the patient's name is added to the pool of patients waiting.

UNOS' kidney allocation policy considers characteristics of both the donor and the transplant candidate in allocating kidneys. A combination of factors determines who receives an offer for which organ, including tissue match between donor and candidate; blood type; blood antibody levels; whether the potential organ candidate is a child; body size of both donor and candidate; geographic factors; and length of time spent on the wait list.

UNOS defines the length of time on the list as the longest time a patient has waited at any center (or the "primary wait time"). A patient may list at multiple centers. A patient may also transfer time from one center ("Initial Primary Center") to another ("New Primary Center") without losing primary wait time, so long as the transfer is handled according to OPTN policy. In order not to lose any primary wait time as a result of switching centers, the patient must consent in writing to the transfer of time (using a "Wait Time Transfer Form") and be evaluated, accepted, and listed by the New Primary Center. The listing process includes the New Primary Center ensuring that required information, such as the patient's ABO type, is accurate.

After receipt of a Wait Time Transfer Form, the date the candidate met wait time criteria at the New Primary Center will be changed by UNOS to the date the candidate met wait time criteria at the Initial Primary Center. The candidate will be assigned a new primary wait time date on the wait list. After receipt of a request to transfer time, the patient will be removed from the Initial Primary Center's wait list once the patient is accepted at the New Primary Center and UNOS will send notice of the transfer to each center involved.

² Source: UNOS Policies & Bylaws (Organ Distribution, Section 3.0 et seq.)

Every time an organ is donated, each transplant candidate in the pool is matched by the UNOS system against the donor characteristics. The UNOS system then generates a list of patients, called a "match run," for each organ that is procured from that donor in ranked order according to UNOS organ allocation policies and any approved variances of the local Organ Procurement Organization. Only active candidates are eligible to be included in the match run. A patient may be added to a center's list, but may not be considered "active," i.e., eligible for matching. Thus, any patients listed on a transplant center's wait list as "inactive" (e.g., because of poor health or good renal function) will not be eligible to be included in the match run. Before a transplant candidate can be activated on the UNOS list, he or she must meet certain clinical criteria (for example, have renal function at 20% of normal or lower). The transplant center determines when a patient can be activated on the center's wait list.

While an organ may match a particular transplant candidate, there is no guarantee that the organ will be transplanted in that individual. There are many factors, related to either the organ or the patient, which can result in the organ being declined. The decision to decline an organ is made by the physicians at the transplant center where the potential recipient is wait-listed. If an organ is declined, it is offered to the next candidate on the match run list.

Thus, while the Plan acknowledges its responsibilities under the Knox-Keene Act, transfer of wait time, maintenance of accrued wait time records, and organ offers based on wait time are all within the scope and jurisdiction of UNOS and are also influenced by the actions of the local Organ Procurement Organization. Moreover, re-listing and the transfer of accrued wait time is not solely the responsibility, nor within the complete control, of any renal transplant center, including the RTC at KFH-SF.

A P P E N D I X E

E. TRANSITION PLANS – MEMBER TRANSFER TO UCSF OR UCD RENAL TRANSPLANT CENTERS

PLAN’S NARRATIVE DESCRIPTION OF TRANSITION PLAN

Upon deciding with KFH-SF to suspend operation of the RTC, the Plan identified an immediate need to effectuate an orderly transfer of patients, including their accrued wait time on the UNOS wait list, to the other contracted transplant programs. In May 2006, the Plan and the KFH-SF RTC began developing a formal transition plan to coordinate the transfer of transplant members from the wait list at the RTC to the wait lists of the renal transplant centers at UCSF or UCD.³

The transition plan was developed in collaboration with UCSF and UCD, in cooperation with UNOS and the California Department of Health Services (“DHS”), subject to review and approval of the Centers for Medicare & Medicaid Services (“CMS”), subject to onsite review by the Health Resources and Services Administration (“HRSA”) of the U.S. Department of Health and Human Services, and subject to the supervision of the Department. The transition plan is continually evolving, and includes provisions for documenting a meticulous, step-by-step approach to the transfer of Plan members to the transplant programs at UCSF and UCD.⁴

On May 23, 2006, representatives from the Plan, the KFH-SF RTC, The Permanente Medical Group (“TPMG”), UCSF, UCD, UNOS, DHS and the Department began to meet weekly to begin implementing the transition plan. (See the attached Appendix A for a copy of the transition plan, current as of the date of submission of this Response.) In addition, the Plan, the RTC and TPMG maintain contact between meetings, by phone, to resolve unforeseen issues that may have arisen during the week. These meetings will continue until the successful transfer of all members, with their accrued wait times, to the UCSF and UCD wait lists is completed (except for those members who may be de-listed, as noted in footnote 1).

The transition plan sets forth the specific steps that each affected entity shall take to transfer patients with wait times from the RTC to UCSF or UCD. The transition plan includes identification of all RTC patients listed on the RTC’s UNOS wait list, as well as the identification of patients who are eligible for transplant wait listing, but who are not yet wait listed. The identification of these patients was based on review of KFH-SF’s ESRD patient population database and the UNOS wait list as of May 4, 2006. (See Appendix B for a copy of the policy and procedure “Transfer to Outside Renal Transplant Program.”)

In order to effectuate an orderly transfer of patients to UCD and UCSF, the Plan provided a blanket authorization for all members who require transplants to receive medically necessary transplants at either UCD or UCSF. The RTC categorized patients for transfer based on clinical

³ During the transition period, the RTC will continue to provide clinical services for patients currently wait-listed at the RTC. The RTC also will continue to perform transplant surgeries as deceased donor organs become available and living donors are identified and deemed clinically appropriate, for any appropriate patients who wish to have their transplants performed at KFH-SF.

⁴ Again, please note that non-member RTC patients may be transferred to transplant programs other than UCD and UCSF, depending on their insurance coverage.

status and wait list times. On May 24, 2006, letters approved by the Department were sent to all patients identified as described above, notifying them that the RTC would transition their transplant-related care to another transplant program.

In or around the last two weeks of May 2006, calls were made to patients in the RTC's first transfer category and to patients with living donors to ensure that these patients had determined their medical center preference for transplant, i.e., to UCD or UCSF. At the end of May, the actual transition process began; patients with living donors and patients currently ready for transplant were transferred.

The transfer process includes providing the receiving facilities with each patient's authorization number. The authorization number represents formal authorization by the Plan to cover transplant care at the designated transplant center. In addition, the RTC has held several meetings with UCD and UCSF to develop a medical record format that will allow the RTC to effectively and expeditiously transfer required medical record information to the respective transplant programs.

Based on these requirements, the RTC began to assemble copies of each transferring patient's medical records to send to the transplant facility selected by the patient. In addition to providing hard copies of medical records, KFHSF has granted UCSF and UCD appropriate access to medical record information in KFHSF's electronic medical record system. This ensures timely access for UCD and UCSF to updated medical information on transplant candidates.

The Plan and the RTC are working with UCSF and UCD on a daily basis via frequent phone contact, to complete the orderly transfer of patient medical records to each facility's renal transplant center. The RTC is currently transferring a total of 35 patient records per day to the facilities (25 per day to UCSF and 10 per day to UCD).

In addition, the RTC, UCD and UCSF work together to identify and coordinate any clinical testing still required before each patient is deemed ready for transplant. These tests are provided at either KFHSF, UCD or UCSF, depending on the test.

The transition plan also addresses the needs of Plan members who may be newly referred for transplants by Plan physicians. These patients will be evaluated and wait listed by the facility of their choice (UCD or UCSF). The patient's medical records will be provided to the patients' preferred renal transplant center (in accordance with the same process described above), which will then coordinate transplant care for the patient.

The RTC and the Plan have developed talking points and call center scripts to enable informative responses to patients who call the Plan and the local Member Services Call Center at KFHSF with questions about the transition process. These materials have been shared with UCD and UCSF so that they know what information is being provided to members about the transition process.

In addition, letters have been developed to send to patients who are on the RTC's wait list, requesting their facility preference for transplants (i.e., UCSF or UCD) and asking patients to

complete UNOS wait transfer forms. These letters were reviewed by the Department and the other entities participating in the weekly coordination meetings and are being sent in a staggered fashion to patients, in order of transfer category. In the event a patient fails to respond to the letters, the RTC has made, and will continue to make, other attempts to contact these patients to ensure timely and effective transfer to either UCD or UCSF. For example, the RTC has engaged the renal dialysis case managers to talk with patients about the transfer process during their normally scheduled appointment times.

The Plan, the RTC, and TPMG have also coordinated the sharing of information between UNOS and the entities involved in the transition plan to resolve any questions about patients whose wait list status may still be unresolved. The RTC is collecting and transmitting the UNOS Wait Time Transfer Form to UNOS for members who choose to receive their transplant at UCSF. Since a patient's wait time cannot be transferred to UCSF until the patient has signed a UNOS wait transfer form, the Plan and the RTC have focused on making sure that each patient has received, signed, and returned the form. UCD will have the patient sign the form at UCD after UCD has evaluated and decided to accept the patient. The Plan and the RTC will continue to transfer patients and their medical records in an orderly fashion to UCSF or UCD until all patients on the RTC transplant wait list have been transferred, along with their accrued wait times (except for those who are de-listed).

During the transition period, patients will continue to receive updates from the Plan and the RTC regarding the transfer process and time frames until they are successfully transferred to the facility of their choice. The RTC will also provide regular updates and information to Plan nephrologists, renal case managers and RTC staff so they in turn can provide information and assistance to patients. Patients will remain listed on the RTC's wait list until they receive written notification that they have been listed at the renal transplant center they selected and that their accrued wait time has been transferred (or that they have been de-listed). The Plan believes the transition will be completed by the end of 2006.

PLAN'S DETAILED TRANSITION PLAN

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
1	Operations/ List Management	Create/maintain a fully reconciled and accurate master list of patients.	Accurate, updated list	Ongoing	In progress. Continuing to update/reconcile list as patient status changes.
2	Operations/ List Management	Maintain UNOS waitlist according to UNOS policies; update list throughout transition.	UNOS informed of updates	Ongoing	In progress
3	Operations/ Patient Transfer	Pre-transplant Coordination – Designate a Registered Nurse transplant liaisons to each UC and other KP medical centers to ensure continuity of care and communication.	Coordinator assigned	1-Jun	Completed. RN coordinators have been designated.
4	Operations/ Patient Transfer	Group 1 - Status I - Currently ready for transplant - as kidneys become available prior to patient transfer to UC, KP will contact patients to offer kidneys to them for surgery at KP. KP will inform patients that they have the choice to have surgery at KP or transfer to UC evaluate and prepare patients for transplant work with patients to sign wait time transfer forms Following the transfer of wait time, care will be coordinated through each patient's KP Nephrologist	Transfer confirmation from UC	31-May	All Group 1 tray patients' medical records have been received by UCSF and UCD. Transfer will be completed when patients are listed at UCs Medical release forms do not need to be signed when KP refers patients for outside care.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
5	Operations/ Patient Transfer	Group 1/Status I - Currently ready for transplant - KP/UCSF - KP will fax UCSF Referral form, signed UNOS transfer form, authorization form and all patient records to UCSF w/in 24 – 48 hours after patient contact. KP will send UNOS form to patients and will make Renal Case Managers (Lori Walker) available to assist patients with completing the form. Renal case managers will also give letter (reviewed by UCSF) to patients explaining transfer process and that until transfer is completed (24-72 hrs), an organ may be offered to KP for transplantation. - UCSF will review the chart w/in 24 hours, assume care of patient and contact the patient w/in 5 business days. UCSF will continue to coordinate care directly with patient and patient's nephrologist. All documentation that is sent to patient will be copied to patient's current nephrologist and dialysis unit.- UCSF will arrange confirmation of blood type by checking availability in UCSF STOR system. - UCSF will secure Transplant Board approval- UCSF will make appointment for patient to be seen within one week if they are available.	Transfer confirmation from UC	31-May	Same as above

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
	<i>continued</i>	Group 1/Status I - KP/UCSF continued- UCSF will fax UNOS transfer form once review of records is complete (w/in 24 hours of receipt)- Once transfer complete by UNOS, UCSF will notify CTDN of patient's transfer to UCSF so that when organ becomes available, CTDN will know to contact UCSF- Patients will be activated to trays by UCSF utilizing CTDN policy once all testing has been completed and UCSF Transplant Board has approved patient for transplant- Patients will be activated monthly to UCSF trays as outlined by CTDN policy until such time they receive their transplant or medical condition changes (i.e. myocardial infarction, development of cancer etc).- Patients will be required to submit monthly blood specimens utilizing current system in place at UCSF.	Same as above	Same as above	Same as above

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
6	Operations/ Patient Transfer	Group 1/Status I - KP/UCD- Status I are top priority for transfer to UCD as well- Provide patient list to UCD that includes patient name, address, telephone number and name, address, telephone number of KP nephrologist. Also include UNOS wait list date- UCD will assist patients with UNOS wait list transfer request form.- Patients remain at KP until patients receive written notification of transfer from UCD. Patients may receive transplant at KP prior to transfer if organ becomes available- Follow above process, modify as needed for UCD.	Transfer confirmation from UC	31-May	UCD is reviewing Group 1 patient records and is beginning to schedule patients. Evals must be completed prior to listing patients on wait list.
7	Operations/ Patient Transfer	Group 1 - Current Living Donor Patients: - Continue to provide care prior to transfer of care to UC - Following transfer care will be coordinated through each patient's KP nephrologist	Transfer confirmation from UC	31-May	All Group 1 current living donor medical records have been received by UCSF and UCD. Transfer will be completed when patients are listed at UCs.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
8	Operations/ Patient Transfer	Group 1 - Current Living Donor Patients - KP/UCSF: KP will complete and fax UCSF Referral form authorization and all patient and donor records- UCSF will review chart within 24 hours of receipt and contact the patient within five business days. UCSF Patient Information Packet will be sent to patient- UCSF will obtain patient signature on UNOS Transfer Form and fax to UNOS- If no additional testing is necessary UCSF will schedule appointment w/in 2 wks and surgery w/in 3 wks- If additional testing is necessary: donors w/KP MRN will complete testing at KP; donors who are in process completing testing with their own physician will continue under the coordination of UCSF; and if testing has not started, UCSF will arrange testing.	Transfer confirmation from UC	31-May	Same as above

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
9	Operations/ Patient Transfer	Group 1/Current Living Donors - KP/UCD- Current Living Donors are top priority along with Status I for UCD as well- Following review of records and clinic visit, patients who meet UCD criteria will be scheduled for surgery as expeditiously as possible- Follow above process, modify as needed for UCD.	Transfer confirmation from UC	31-May	UCD is reviewing current living donor records and will determine medical and surgical suitability for transplant. Evals must be completed prior to listing patients on wait list. If have complete work ups for both donor and recipient, pre-op evals can be scheduled beginning 6/2 and surgeries can be scheduled beginning 6/5.
10	Operations/ Patient Transfer	Group 2 - Deferred Patients – - transfer to UC, UC to evaluate and complete process of wait-listing patients - For UCD - deferred patients will receive next level of priority for transfer. KP will provide list of patients to be transferred - all Medical records to be sent.	Transfer confirmation from UC	9-Jun	UCSF will access Group 2 patients' clinical information via CIPS. Began to send Group 2 patients' information to UCSF and UCD week of 6/12.
11	Operations/ Patient Transfer	Group 2/New Referrals - KP/UCSF- Approx 200 pts to be evaluated by mid October - 4-6 weeks after 3 month process to complete first two groups- KP to provide UCSF list w/names of patients and referral date to prioritize appointments- KP to contact patient to determine Transplant Center choice- If UCSF, KP to fax UCSF referral form, authorization form and patient records to UCSF- Upon receipt of above documents, UCSF will assume care of patient and contact patient w/in 5 business days. Patients will be given appointment dates "within" three mo. of contact with pt., prioritized by time waiting for appt.- UCSF will continue to coordinate care directly with patient and KP nephrologist.	Transfer confirmation from UC	12-Jun	Same as above. UCSF and UCD will evaluate new referrals.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
	<i>continued</i>	All documentation by UCSF that is sent to patient will be copied to patient's current nephrologist and dialysis unit.- UCSF will document receipt of referrals of patient by KP on UCSF's patient tracker form weekly indicating date received.- UCSF will assume coordinating care for patient at the time of initial contact with patient - Transplant Consult note will be forwarded to KP nephrologist upon completion of evaluation.	Same as above	Same as above	Same as above
12	Operations/ Patient Transfer	Group 2/New Referrals - KP/UCD- UCD will schedule based on standard scheduling criteria for initial pre-transplant visit- New referrals will be processed and scheduled after Status I, living donor and deferred patients have been contacted and offered appointments.	Confirmation from UC that pt is in UC system	12-Jun	Same as above
13	Operations/ Patient Transfer	Group 3 - Newly-Identified Living Donors Existing patients who have recently identified potential donor/s - Transfer to UCD - follow same process as for all other UCD patients - Transfer to UCSF - follow same process as for UCSF Status I/tray patients	Transfer confirmation from UC	26-Jun	Began sending Group 3 patients' charts week of 6/26.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
14	Operations/ Patient Transfer	Groups 4UCSF Group 4: patients prioritized by blood type and time on wait listUCD Group 4: patients who were previously UCD patientsIncludes KP-designated groups: Status II – Patients requiring additional testing prior to being ready for transplant, Status C/S - on medical or psychiatric hold based on existing clinical findings, and Graft Failure patients- Contact to discuss additional screening and explain the transfer process - Before wait time is transferred KP will continue to perform required testing, track test results and update each patient's medical record- Obtain signed wait list transfer request forms as needed, send along with medical records to center preferred by patient as received- Patients currently on medical or psychiatric hold based on existing clinical findings will be flagged for review by UCs- Graft failure patients who are not currently accumulating wait time will be referred to UC for assessment- Following the transfer of wait time, care will be coordinated through each patient's KP nephrologist.	Transfer confirmation from UC	5-Jul	Patients have been sorted based on requested criteria from UCSF and UCD. Patients who selected UCSF have been resorted to ensure prioritization matches UCSF criteria: blood type, wait time, sensitized v. unsensitized. UCD requested Group 4 patients be prior UCD patients.Began to transfer patient charts week of 7/3.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
15	Operations/ Patient Transfer	Group 5 - Patients remaining on cadaveric list who do not fall into the above categories – May also include KP-designated groups Status II, Status C/S and Graft Failure, based on wait times- Transfer to UC based on current wait time on the list. Patients with the longest wait times will be transferred first. - Obtain signed wait list transfer request form and send along with medical records to center preferred by patient as received. Prioritize follow-up based upon wait time. - Following the transfer of wait time, care will be coordinated through each patient's KP nephrologist.	Transfer confirmation from UC	31-Jul	Chart transfer estimated to begin end of July/beginning of August. Will identify preference via letters and follow up phone calls.
16	Operations/ Patient Transfer	Group 5 - All other patients - KP/UCSF- Patients will be prioritized by blood type and time on wait list. - KP to obtain signed UNOS transfer form and fax to UCSF along with UCSF Referral form, authorization form and all patient records- Upon receipt of referral, UCSF will assume care of patient and contact patient w/in 5 business days. UCSF will continue to coordinate care directly with patients and their KP nephrologist. All documentation by UCSF that is sent to patient will be copied to patient's current nephrologist and dialysis unit. Dr. Lubbock will be contact for assisting UCSF during transition with Kaiser cardiology work-ups or other clinical tests to be performed at KP.- UCSF will fax transfer form to UNOS if after review of records patient would appear to be reasonable candidate for transplant.	Transfer confirmation from UC	31-Jul	Same as above

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
	<i>continued</i>	<p>Patient will be counseled upon initial contact by UCSF that approval for transplant is contingent on final approval by Transplant Board and changes in their medical history- If patient is not a transplant candidate, UCSF will mark tracker form and contact KP nephrologist. – If patient's candidacy is borderline, UCSF will get more tests/information and schedule pt to be seen.</p> <p>Group 5 - All other patients - KP/UCSF - continued- UCSF will use blood type/wait list prioritization to make appointments for patient to be seen within two months of completion of studies. However, if patient's waiting time is such that they are within three months of top of current tray list, they will be given appointment to be seen sooner. UCSF will also prioritize patients according to ITL information of likelihood for 0 mismatch organ offers when this information becomes available.- Once patient completes medical testing and UCSF obtains them they will be reviewed by the Transplant Board to determine if any further tests are necessary. If so, patient will be contacted by UCSF directly and letter sent to patient and nephrologist outlining tests.- If determined medically cleared by UCSF Board for Trays, they will be activated monthly by UCSF on trays as outlined by CTDN policy until such time they receive their transplant or medical</p>	Same as above	31-Jul	Same as above

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
	<i>continued</i>	condition changes (i.e. myocardial infarction, development of cancer etc).- Patients will be required to submit monthly blood specimens utilizing current system in place at UCSF. - If patient after completion of tests is determined not to be a candidate for transplant, the patient and KP nephrologist will be contacted by UCSF and patient will be removed from list. UC will notify KP Liaison if patient determined not to be a candidate.	Same as above	31-Jul	Same as above
17	Operations/ Patient Transfer	New Patients Referred directly to UCs from KP Nephrologist- UCSF will follow above procedure depending on type of patient. Appointments will be scheduled up to 4 months from date of referral; UCSF instructed to prioritize above patients first. Dr. Tomlanovich to send communication to Dr. Madvig for distribution to Kaiser nephrologists. Dr. Madvig also to facilitate other UCSF communication/interaction with Kaiser nephrologists. KP nephrologist staff to fax UCSF referral, authorization & patient records- KP nephrologists will also refer directly to UCD for evaluation.	Confirmation from UC that pt is in UC system	30-May	New patients are now being referred directly to UCSF and UCD and UCs are beginning to schedule patients for appointments. Continuing to communicate internally with KP nephrologists and renal case managers to provide regular updates and information.
18	Operations/ Patient Transfer	Eligibility Status Pending – - Transfer patients to UCSF or UCD based on identified preference	Decision made on next steps for patient and communicated to UC and patient as needed	5-Jun	In process of reviewing charts and membership status.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
19	Operations/ Patient Transfer	Non-members -Non-members are included in patient prioritization by grouping. Contact non-members by group, along with members, to identify preference for UCSF or UCD. Transfer patients, including any clinical information, following same process and timeline as members. As needed, Financial Counselors will make outreach calls to non-members.	All non-members successfully transferred	1-Jun	In process of reviewing membership status for all patients. Developing letter and talking points for non-member outreach.
20	Operations/ Patient Transfer	Authorizations - generate authorization for each patient and send the authorizations to UC - For UCD, KP will provide 2 auths upon referral - the first for pre-transplant care, the second for transplant admission. The second auth will be placed on "hold" status and will be activated upon notice from UCD of transplant admission	All authorizations generated and sent	26-May	Continuing to generate authorizations and sending to UCs with each patient's clinical information.
21	Operations/ Patient Transfer	Clinical Information - KP will provide relevant clinical information for each patient who will be transferred to UC. Includes hard copies of patient medical records and access to KP clinical information system.	All patient medical records sent; Electronic access agreed to and established; UC staff/MDs trained	23-May	Clinical Information: Agreed with UCSF on revised requirements: 16 tabs no longer needed. Provide signed UNOS form, auths, progress notes, EKG and long-term care plan including, if available, dietary and psycho-social consults. Created checklist and transfer tracking tool to confirm information sent/received. IT: UCSF - Created additional access to CIPS for 20 UCSF providers/staff and provided training on 6/2. 4 add'l UCSF staff added on 6/26. Implemented VPN tunnel with UCSF 6/15 to enable CIPS printing. UCD - Created CIPS access for 13 UCD providers/staff, trained on 6/15. Created capability for CIPS printing at UCD 6/30.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
22	Operations/ Patient Transfer	UNOS Transfer – develop an expedited process for the transfer of wait time as well as an electronic tracking system. Patients notified within 10 days of removal or placement on the UNOS waiting list.	UNOS process finalized, patients successfully transferred	23-May	Reached agreement on expedited process. Obtained form from UNOS 5/29. Began sending UNOS form to Group 1 UCSF patients 6/1, Group 4 on 6/28 and first half of Group 5 on 7/10. Making outreach calls to Groups 1 and 4 to follow up. Sending UNOS form to all Group 5 patients to request that they indicate preference for UCSF or UCD and return their completed and signed form to KP. Will also make outreach calls to follow up on Groups 5 as needed.
23	Operations/ Patient Transfer	Transfer Verification – document in tracking system successful transfer of all patient wait times and completion of documentation – UCSF to forward to KP its Tracker Form weekly.- KP to forward to UCSF its Tracker Form weekly.- UCSF to keep UCSF tracker up to date on weekly basis.	System created and communicated; tools finalized and shared	29-May	Ongoing. Created enhanced patient transfer tracking tool for monitoring transition of patients and completion of all required documentation. Providing daily status reports and weekly updates to the DMHC.
24	Member Communication	Notification of Transfer - Send written notification to patients that their transplant services will be transferred to UC. Provide additional information/ updates to patients throughout transition.	Letter sent	24-May	Completed. Patient letter #1 sent to all patients – notification of transfer.
25	Member Communication	Notification of Patient Rights and Responsibilities - Inform patients of their rights and responsibilities via letter	Letter sent	26-Jun	Drafted letter for review and approval. Will send in advance of 7/15 deadline.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
26	Member Communication	Contact patients through SF Call Center to identify preference of UCSF or UCD. Process for patients who cannot be reached through preference outreach calls (non-responder process): SF Call Center will make multiple attempts to contact patients over a week-long period. If unsuccessful, renal case managers will make outreach calls to patients. If patient is still not contacted, renal case managers will contact patients at dialysis center when patients come in for appointments. Identifying patient preference for Group 5: Send update letter requesting patients to identify preference for UCSF or UCD, along with UNOS form for all patients. No longer sending certified mail per agreement with DMHC. Make follow up outreach phone calls one week after sending letter to assist patients with completing UNOS forms as needed.	All patients contacted and preferences identified	24-May	All Group 1 patients have identified preference. All but one patient in Groups 2 and 3 have identified preference. 96% of Group 4 patients have identified preference. Additional outreach calls in progress. Implementing non-responder process as needed.
27	Member Communication	Send patients a Transfer Initiation letter with transfer information and UNOS wait list transfer request form (UCSF cadaveric and new living donors). Send in waves based on prioritized groupingFor Group 5: Include UNOS form in update letter and request patients to return completed and signed form. Follow up with outreach calls as needed.	Patients receive	30-May	Transfer initiation letter with overview of transfer process sent to Group 1 patients beginning 6/1. Included UNOS transfer form for UCSF tray pts. Letter for Group 2 sent beginning 6/9. Group 3 letters sent 6/18. Letter for Group 4 sent beginning 6/28. Group 5 letter sent 7/10 to first half of patients based on blood type and wait time. Second half of Group 5 letters will be sent beginning 7/31. Outreach calls will be made to patients to assist with completion and return of UNOS forms. Renal case managers will provide assistance to patients.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
28	Member Communication	Contact patients to confirm receipt and provide assistance completing UNOS forms (UCSF).	All contact made and documented	30-May	Renal case managers began following up with Group 1 patients on 6/2 and Group 4 patients on 7/10. Assistance to Group 5 begins 10 days after Group 5 letter sent for both waves of Group 5 patients.
29	Member Communication	Provide updates/information to patients who have not yet been transferred regarding transfer process and timeframes - Group 5.	Patient letter sent	26-Jun	Merged updated letter with transfer initiation letter for Group 5. Letter sent to first half of Group 5 patients on 7/10. Letters for second half to be sent beginning 7/31.
30	Member Communication	Provide regular updates/information to nephrologists, renal case managers and Transplant Services staff to enable them to provide assistance to patients.	Nephrologists and renal case managers are able to assist patients with transition questions	1-Jun	Ongoing. Bi-weekly communications began 6/1. Also meeting with nephrologists and renal case managers to inform/update.
31	Member Communication	Send signed UNOS transfer form to UCSF upon receipt. Provide to UCSF a list of all patients who have completed the wait time transfer request forms and send forms along with clinical information to UCSF.	All patients notified	12-Jun	In progress of providing information to UCSF upon receipt from patients.
32	Member Communication	Send UNOS transfer confirmation letter to patients.	All patients notified	12-Jun	Began sending patient letter confirming KP receipt of UNOS transfer form to Group 1 patients week of 6/26. Will be sent on rolling basis as UNOS forms are received.
33	Member Communication	Obtain copies of letter UCs send to patients confirming transfer from KP to UCs	All letters obtained	30-Jun	UCs have agreed to provide letters
34	Member Communication	Track all documents sent and received; contact patients who have not submitted documents on weekly basis.	All completed forms received	31-May	Tracking documents in patient transfer tracking system.

Item #	Category of Work	Tasks	Metrics/ Success Criteria	Start Date	Status/Next Steps
35	Member Communication	Send patients final KP transfer confirmation letter after UNOS transfer and transfer to UCSF/UCD are completed.	Confirmation of receipt by patients (cert. mail)	19-Jun	Transfer confirmation letter approved. Will be sent upon receipt of transfer confirmation letter to patients from UCs.